# NAVAL POSTGRADUATE SCHOOL
# MONTEREY, CALIFORNIA

# THESIS


**MEDICARE SUBVENTION AND THE MILITARY HEALTH SERVICES SYSTEM**

by

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December, 1995

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# REPORT DOCUMENTATION PAGE

Form Approved OMB No. 0704-0188



| 1. AGENCY USE ONLY *(Leave blank)* | 2. REPORT DATE<br>December, 1995 | 3. REPORT TYPE AND DATES COVERED<br>Master's Thesis |
|---|---|---|

4. TITLE AND SUBTITLE: Medicare Subvention and the Military Health Services System

5. FUNDING NUMBERS

6. AUTHOR(S) Bruce M. Miller

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
Naval Postgraduate School
Monterey CA 93943-5000

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)

10. SPONSORING/MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES The views expressed in this thesis are those of the author and do not reflect the official policy or position of the Department of Defense or the U.S. Government.

12a. DISTRIBUTION/AVAILABILITY STATEMENT
Approved for public release; distribution is unlimited.

12b. DISTRIBUTION CODE

13. ABSTRACT *(maximum 200 words)*

This thesis examines Medicare Subvention and the effects it would have on the Military Health Services System. Current Medicare Subvention legislation is identified and reviewed. The role on the Health Care Financing Administration and how it relates to Medicare and Medicare Subvention is addressed. Improving access to care for military Medicare-eligible retirees and authorizing Military Treatment Facilities to bill for the health care services provided to this group are the primary advantages that Medicare Subvention would provide. The thesis concludes that approval and implementation of Medicare Subvention would have positive effects on medical readiness, access to care for military Medicare-eligible retirees, and Medicare. Furthermore, not passing Medicare Subvention would negatively impact medical readiness and access to care for retirees age 65 and over.

| 14. SUBJECT TERMS Medicare, Subvention, Access | | | 15. NUMBER OF PAGES 61<br>16. PRICE CODE |
|---|---|---|---|
| 17. SECURITY CLASSIFICATION OF REPORT<br>Unclassified | 18. SECURITY CLASSIFICATION OF THIS PAGE<br>Unclassified | 19. SECURITY CLASSIFICATION OF ABSTRACT<br>Unclassified | 20. LIMITATION OF ABSTRACT<br>UL |

NSN 7540-01-280-5500

Standard Form 298 (Rev. 2-89)
Prescribed by ANSI Std. 239-18 298-102

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# MEDICARE SUBVENTION AND THE MILITARY HEALTH SERVICES SYSTEM

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Submitted in partial fulfillment
of the requirements for the degree of

**MASTER OF SCIENCE IN MANAGEMENT**

from the

**NAVAL POSTGRADUATE SCHOOL**
**December 1995**

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## ABSTRACT

This thesis examines Medicare Subvention and the effects it would have on the Military Health Services System. Current Medicare Subvention legislation is identified and reviewed. The role on the Health Care Financing Administration and how it relates to Medicare and Medicare Subvention is addressed. Improving access to care for military Medicare-eligible retirees and authorizing Military Treatment Facilities to bill for the health care services provided to this group are the primary advantages that Medicare Subvention would provide. The thesis concludes that approval and implementation of Medicare Subvention would have positive effects on medical readiness, access to care for military Medicare-eligible retirees, and Medicare. Furthermore, not passing Medicare Subvention would negatively impact medical readiness and access to care for retirees age 65 and over.

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# I. INTRODUCTION

## A. BACKGROUND

Medicare Subvention could significantly enhance access to care at Military Treatment Facilities (MTFs) for military retirees eligible for Medicare. In addition to the increase in access for military retirees, Medicare Subvention could positively affect many other aspects of the military health services system. The potential impacts of Medicare Subvention will be individually discussed in future chapters.

Although Medicare Subvention is a new term to most military health care officers, the topic originated during the Reagan Administration. However, the Bush Administration did not support the idea of changing the existing Medicare system. Therefore, Medicare Subvention received little attention during this administration from the Military Health Services System (MHSS) in the Pentagon. (Interview with Giambone, 1995)

When the Clinton Administration took office, Medicare Subvention reemerged as an issue for the MHSS. With the increase in attention to healthcare in America created by the Clinton healthcare reform proposal, Medicare Subvention gained importance in the provision of military healthcare services. Today, specific offices in the Pentagon and Bureau of Medicine and Surgery have personnel responsible for the development of a Medicare Subvention option. Specifically, it is a major priority for the Office of the Assistant Secretary of Defense, Health Affairs at the Pentagon. (Interview with Giambone, 1995)

Medicare Subvention is a policy change to the existing relationship among Medicare, MTFs, and eligibility for the Civilian Health and Medical Program of the Uniformed (CHAMPUS). Medicare Subvention means that Medicare would reimburse the Department of Defense (DoD) for care provided by DoD to military Medicare-eligible beneficiaries, which currently is not allowed by law.

There are 1.2 million military beneficiaries age 65 and older, of which 324,000 are estimated to use Military Treatment Facilities (MTFs) for health care (Department of Defense, Office of the Secretary of Defense (Health Affairs), 1995, pp. 1-2). Military retirees only receive care on a "space available" basis at MTFs. Available space to treat retirees is diminishing due to closures and downsizing of MTFs. Retirees forced to use civilian providers for care generate higher medical charges than they do when they receive care at an MTF. The costs associated with civilian provided health care reimbursed by Medicare typically exceed costs for the same care available from an MTF.

## B. MEDICARE SUBVENTION AND CAPITATION BUDGETING

The mission of MTFs is to provide quality care to active duty members, their dependents, and military retirees. Under the new capitation budgeting system being implemented by the OASD(HA), MTF budgets are based on a capitated rate. This capitation model is a population driven system designed to ensure proper funding for MTFs. The capitation rate is calculated by adding Operations and Maintenance (O&M), Military Personnel (Milpers), Civilian Health and Medical Program of the Uniformed

Services (CHAMPUS) funds and dividing by the MTF's catchment area population (Interview with Mr. Chan, 1995). Population, the denominator of the formula, is determined by the number of estimated users of an MTF. The number of users is based on Full Time Equivalent users (FTEu). Retirees are included in the calculation of the total beneficiary population in the catchment area.

$$\frac{\text{O\&M + Milpers + CHAMPUS}}{\text{Catchment area population (FTEu)}}$$

O&M is an account used by activities to fund their base operations. Examples of base operations include utilities, facility maintenance, and civilian personnel pay. A portion of this funding associated with military health care operations is included in the capitation formula. The amount is determined retrospectively by reviewing prior year actual costs and inflating these figures to reflect current year rates. This category of funding is added to the numerator of the capitation formula. (Bureau of Medicine and Surgery, Defense Health Programs, 1995, pp. 1-17)

Milpers is a significant component of the capitation formula. The Bureau of Naval Personnel manages this fund for MTFs. Military personnel costs are broken down into two categories: officer and enlisted. The Medical Expense and Performance Reporting System (MEPRS) is used by MTFs to collect manpower expense data. Unfortunately, this method of manpower data collection is not consistent with military personnel costing used by the Bureau of Naval Personnel. A result of this inconsistency is

that the Bureau of Naval Personnel does not always staff an MTF to the level of need identified by the MTF's Commanding Officer. A shortfall in staffing can lead to an unmet demand from MHSS beneficiaries who will need to receive medical care outside the MTF. (Bureau of Medicine and Surgery, Defense Health Programs, 1995, pp. 1-17)

In the capitation formula, MTFs by definition are given CHAMPUS dollars in their appropriations. Each time an MTF refers a patient outside the facility, it is an expense to the capitation budget. Inappropriate referrals can place a financial stain on an MTF budget.

It is important to note that retirees are not included in the determination of Milpers funding and retirees over the age of 65 are not eligible for CHAMPUS. The result of Medicare-eligible military retirees being excluded in the numerator but included in the denominator is a reduced capitation rate for an MTF.

## C. RESEARCH QUESTION

The primary research question is: "What effect would Medicare Subvention have on the Military Healthcare Services System?"

Subsidiary questions to be addressed include:

* What impact would Medicare Subvention have on costs of providing care to military Medicare-eligible beneficiaries?
* Would Medicare Subvention affect access to Military Treatment Facilities for elderly retirees?

* Would Medicare benefit from elderly military retirees obtaining care at Military Treatment Facilities versus civilian facilities?
* How would Medicare Subvention affect military readiness?
* What policies regarding Medicare Subvention have been advocated by Congress and DoD?

## D. SCOPE

This thesis will examine the benefits to DoD, Medicare, and military retirees over 65 with the passage of Medicare Subvention. I will review past and current Medicare Subvention legislation. Tricare Prime, DoD's managed health care system, will receive specific attention due to the impact Medicare Subvention may have on the success of that program. The influence Medicare Subvention would have on military readiness and the Medicare system as a whole will be discussed.

## E. METHODOLOGY

Archival research methods were used to gather data for this thesis, sources used are identified in the list of references. I obtained expert opinion data via personal and telephone interviews with key DoD officials involved in Medicare Subvention. Primary sources for these interviews were the Office of Congressional and Legislative Affairs (Med 83), Bureau of Medicine and Surgery, Office of the Assistant Secretary of Defense/Health Affairs (OASD/HA), Policy and Coordination, the Office of Civilian Health and Medical

Program of the Uniformed Services (OCHAMPUS), and The Retired Officers Association (TROA).

## F. ORGANIZATION OF STUDY

Chapter I, introduces the impact Medicare Subvention could have on the Military Healthcare Service System. The background of Medicare Subvention, scope, methodology, and research questions are discussed in this chapter.

Chapter II addresses past and current legislation related to Medicare Subvention.

Chapter III discusses the Health Care Financing Administration and address a proposed demonstration model of Medicare Subvention.

Chapter IV discusses the effect Medicare Subvention would have on access to care for military Medicare-eligible beneficiaries.

Chapter V examines the effect of Medicare Subvention on Medicare.
In this chapter, I will compare the cost of providing care to military Medicare-eligible beneficiaries in MTFs and civilian facilities.

Chapter VI discusses the effect of Medicare Subvention on military readiness. Specifically, this chapter will review the expanded training available to the medical staff by providing care to the elderly population.

Chapter VII reviews the impacts Medicare Subvention would have on the Military Health Services System. Conclusions and suggestions for future research are provided in this chapter.

## II. HEALTH CARE LEGISLATION AFFECTING MEDICARE SUBVENTION

### A. BACKGROUND

In recent years, the American people's interest in health care has risen significantly. Increased costs of medical care are the principal reason for this growth in interest. Medical insurance has insulated some Americans from the high cost of receiving medical care. Insurance carriers often pay the majority of the medical bill, leaving relatively small out of pocket costs from the insured.

The provision of medical care is unlike most other types of business. In most business ventures, the customer pays the full bill for a good or service and is thus concerned about the price. Customers of medical care with insurance, on the other hand, do not pay the bill, therefore incentivizing customers to consume care and providers to maximize charges. The only impact to customers is the increase in their premium for medical insurance. The effect of this increase is reduced further, because the increased costs to insurance carriers are spread among the total population insured.

However, the increase in insurance premiums has led to more Americans not having medical insurance (Congressional Budget Office Memorandum, 1993, p.17). Some employers that formerly provided medical insurance as a benefit to employees have opted not to pay the additional costs. Often these employees are not able to afford the insurance premium and therefore drop their health care coverage. The lack of medical insurance has led individuals to postpone seeking medical attention until it is absolutely necessary. High medical costs can be avoided with regular and early medical visits which

lead to early diagnosis and treatment of medical conditions in their development phase.

For the reasons above, the pressure for health care reform has been continually increasing in recent years. Individuals without medical coverage and the elderly population concerned about cuts in Medicare benefits have legitimate reasons to desire improvements in the health care system. In response to such concern, health care reform bills have recently appeared in Congress, including a major effort in 1994 that ended in failure. In 1995, both Congress and the President proposed major changes in the funding formula for Medicare and Medicaid. These changes would significantly reduce the growth of federal spending for health care.

## B. HEALTH SECURITY ACT

In 1993, President Clinton proposed his National Health Care Reform Plan to the 103rd Congress. The proposed legislation addressed civilian as well as military health care issues. The President's proposal addressed the issue of allowing military Medicare-eligible beneficiaries to enroll in a Uniformed Services Health Plan. If passed, the President's proposed health plan would have offered the Department of Defense an opportunity to provide retirees and dependents better access to medical care. However, the President's plan failed in Congress.

## C. IMPACT OF HEALTH SECURITY ACT ON DOD

Active-duty personnel, active-duty dependents, retirees, and dependents of retirees are eligible to receive medical care at Military Treatment Facilities (MTF). However, the

priority of delivery of care is first to active-duty, then their dependents, and lastly to retirees and their dependents. Retirees are further subdivided into two groups; military retirees under age 65, and military retirees who are 65 or older and thus eligible for Medicare. This distinction is important, because currently, Medicare-eligible retirees are not CHAMPUS eligible and consequently are prohibited from enrolling in TRICARE Prime, the DoD managed care program.

Currently, MTFs are not reimbursed for care provided to Medicare-eligible beneficiaries. Therefore for financial reasons, it is not beneficial for MTFs to provide care to Medicare-eligible retirees. Without access to MTFs, these individuals must use the Medicare system, which requires higher out of pocket costs. This issue will be discussed in greater detail in a chapter devoted to Medicare.

As previously stated, the Health Security Act addressed military health care issues. The President's plan preserved the existence of the Military Health Services System (MHSS). Furthermore, it allowed DoD, thru MHSS, to develop and manage their own health plan provided that it remained within the guidelines of the President's plan. The plan allowed Medicare-eligible military retirees to enroll in DoD's Military Health Plan (MHP). This would have enhanced access to health care for military retirees. (Mitchell, 1993, pp. 1182-1192)

## D. CUNNINGHAM BILL I

In 1993, Representative Randy Cunningham proposed H.R. 1778 in the 103rd Congress. The purpose of this bill is "to amend the Title 10, United States Code, and Title XVIII of the Social Security Act to permit the reimbursement of expenses incurred by a medical facility of the Uniformed Services or the Department of Veterans Affairs in providing health care to persons eligible for care under Medicare". H.R. 1778 was not supported by the Bureau of Medicine and Surgery or the Department of Defense. (McGraw, 1994, p. 1)

H.R. 1778 proposed to establish medical and dental care at facilities of the uniformed services as an entitlement for dependents and retirees. This is a departure from current policy that MTFs primarily exist to support the readiness mission and provide care to dependents and retirees only on a space available basis (Office of the Assistant Secretary of Defense (Health Affairs), 1993, p. 1). Requiring the provision of care to dependents and retirees based on any criteria other than space availability would change the mission of MTFs which is to provide care to active duty personnel.

Under this bill, MTFs are required to provide care to dependents and retirees unless all of their resources are committed to the delivery of care to active duty members. If a particular service is not available at an MTF, however, the facility is not required to initiate that service in order to provide care to dependents and retirees. These two exceptions are the only reasons under H.R. 1778 for not providing care to dependents and retirees.

## E. THE HEFLEY BILL

House of Representatives (H. R.) 580 was introduced in the 104th Congress by Representative Joel Hefley on January 19, 1995. H.R. 580 is a bill "to amend title XVIII of the Social Security Act and title 10, United States Code, to allow the Secretary of Health and Human Services to reimburse the Military Health Services System for care provided to Medicare-eligible military retirees and their spouses in the Military Health Services System" (Hefley, 1995, p.1). H.R. 580 is supported by the Bureau of Medicine and Surgery and the Department of Defense (Rice, 1995, p.3).

Current law prohibits an MTF from billing Medicare for care provided to Medicare-eligible military retirees. H.R. 580 proposes to change this provision of title XVIII of the Social Security Act, authorizing MTFs to receive reimbursement from Medicare for care provided to these individuals. Without reimbursement from Medicare, there is no incentive for MTFs to administer health care to elderly retirees. With reimbursement from Medicare, through MTF Third Party Collections (TPC), commanding officers of MTFs will increase their available funds and thus be encouraged to enhance the quality and number of services provided to Medicare-eligible military retirees.

Title 10 U.S.C. entitles military retirees and their families to medical care in MTFs on a space available basis. The recent downsizing of the military has included the closing of MTFs, reducing the space available to provide care to all entitled. Current law does not allow retirees age 65 and above to participate in the CHAMPUS program or enroll in TRICARE Prime, further hindering access to care for these retirees. H.R. 580 permits CHAMPUS-eligible beneficiaries who are enrolled in TRICARE to remain in the program

when they become Medicare-eligible at age 65.

An additional provision of H.R. 580 requires Medicare to pay DoD for health care provided to Medicare-eligible military retirees at an MTF. DoD would be reimbursed for care provided to retirees who are enrolled in a military health care plan. Current law prohibits members enrolled in TRICARE Prime from receiving care at MTFs. TRICARE Prime is DoD's version of a civilian Health Maintenance Organization (HMO). H.R. 580 requires the Department of Health and Human Services (HSS) to pay DoD's HMO the same as it would to any civilian HMO.

The passage of H.R. 580 would make Medicare the primary payer of health care for all Medicare beneficiaries. Allowing MTFs to bill Medicare would create an incentive for MTFs to provide care to Medicare-eligible military retirees. As a result of H.R. 580, access to care would improve for elderly retirees. Medicare-eligible military retirees could choose to obtain health care from military or civilian sources.

## F. CUNNINGHAM BILL II

House of Representatives (H.R.) 861 was introduced in the 104th Congress by Representative Randy Cunningham on February 8, 1995. This bill is very similar to H.R. 1778 that Representative Cunningham proposed in the 103rd Congress in 1993. H.R. 861 is opposed by the Bureau of Medicine and Surgery and the Department of Defense (Rice, 1995, p.3).

H.R. 861 proposes to establish care provided to dependents and retirees in an MTF as an entitlement (Rice, 1995, p. 1). The primary mission of MTFs is to provide care to active duty members. Dependents and retirees receive care only on a space available basis.

The bill requires medical and dental care to be provided to retirees and dependents in facilities of the uniformed services. The only exceptions to providing care to these groups are when all of the command's resources are devoted to active duty or when specific services are not available at an particular MTF. However, as an additional stipulation, H.R. 861 requires command's to determine a date that health care services will be provided to retirees and dependents at that command. This only applies to existing services at the MTF. MTFs are not required to launch new services in order to provide care to dependents and retirees. (Office of the Assistant Secretary of Defense (Health Affairs), 1995, p. 1)

H.R. 861 does not address how non-Medicare covered costs will be reimbursed to MTFs. Dental care, which is an entitlement to retirees and dependents under this bill, is not a Medicare reimbursable expense. Therefore, DoD has no financial incentive to provide dental care or other non-Medicare reimbursable services to retirees and dependents.

# III. THE HEALTH CARE FINANCING ADMINISTRATION AND MEDICARE REIMBURSEMENT

## A. BACKGROUND

The support from the Health Care Financing Administration (HCFA) is a key element in the success of Medicare Subvention. Medicare Subvention involves the transfer of Medicare funds to DoD for the reimbursement of health care provided to military Medicare-eligible retirees. HCFA controls the purse strings of the Medicare Trust Fund, and thus their approval is required for the reimbursement of Medicare dollars.

The Health Care Financing Administration (HCFA) manages the Medicare and Medicaid programs, which help pay the medical bills for 70 million Americans. The Department of Health and Human Services (HHS), in conjunction with HCFA, the Public Health Services (PHS), and the Social Security Administration (SSA), administers Medicare, although HCFA has the primary responsibility for Medicare. HCFA formulates policy and guidelines, overseas contracts and operation, maintains and reviews utilization records, and has authority over the general financing of Medicare. PHS is responsible for administering the professional health aspects of Medicare. SSA is responsible for the initial determination of an individual's entitlement to Medicare, and maintains a master Medicare beneficiary record. (HCFA Home Page, 1995)

HCFA has agreements with the Health Departments of each state. These agencies identify, survey, and inspect facilities that provide or want to provide health services in the Medicare program and certify the providers that qualify.

## B. REIMBURSEMENT FROM MEDICARE

As of today, there are approximately 1.1 million DoD beneficiaries that are eligible for Medicare and authorized to receive health care in an MTF. Of the 1.1 million, 324,000 are expected to use an MTF in 1995. The cost to MTFs for providing care to these 324,000 Medicare-eligible military retirees is approximately $1.4 billion. Dividing the users into the total costs of care yields a cost of providing care to each user of $4,322. (Department of Defense, Office of the Assistant Secretary of Defense (Health Affairs), 1995, pp. 1-2)

Currently, DoD is not reimbursed from Medicare the $1.4 billion to provide care to elderly retirees. As a result of this, MTFs absorb the cost of providing this care within their existing budgets. Under current policy, HCFA has not authorized the reimbursement of Medicare funds to MTFs. HCFA now pays nothing for the care Medicare-eligible military retirees receive in MTFs. From HCFA's viewpoint, it has no incentive to begin paying the $1.4 billion. (Interview with Giambone, 1995)

HCFA funds fall under entitlement spending within the federal budget, while MTF budgets are discretionary funding. The Budget Enforcement Act of 1990 created the "PAYGO" requirement for entitlement spending. PAYGO was initiated to keep entitlement programs in the federal budget deficit neutral. Social Security, Medicare, and Medicaid are examples of entitlements. A requirement of PAYGO is that any new action that would increase entitlement spending be offset by eliminating an existing entitlement expense or increasing revenues to cover the additional spending. All of the current programs that fall under entitlements have strong ties to large segments of the population.

Thus cutting or eliminating any of the existing entitlement programs will be politically difficult. (Ripley and Lindsay, 1993, p. 54)

## C. MEDICARE DEMONSTRATION

The Office of the Assistant Secretary of Defense (Health Affairs) (ASD/HA) has proposed to HCFA that a joint DoD/HCFA Medicare HMO demonstration project be conducted. The purpose of this project is to demonstrate that Medicare Subvention would be beneficial for both DoD and HCFA. This demonstration is intended to show that if DoD is reimbursed for health care provided to Medicare-eligible military retirees, HCFA would be saving dollars from the Medicare Trust Fund. (Office of the Assistant Secretary of Defense (Health Affairs), 1995, pp. 1-2)

ASD/HA's proposed plan calls for DoD to remain responsible for the cost of providing care to the first 324,000 Medicare-eligible military retirees that receive care at an MTF. DoD will not be reimbursed for the cost of providing health care to the 324,000, which comes to $1.4 billion with an annual adjustment for inflation. (Office of the Assistant Secretary of Defense (Health Affairs), 1995, pp. 1-2)

Under the demonstration proposal, HCFA would authorize Medicare to reimburse DoD for care starting with the next receiver of care after the first 324,000. HCFA would reimburse DoD 93 percent of the costs of care provided. The 93 percent applies to medical costs that Medicare currently reimburses civilian HMOs. DoD will not be reimbursed for costs not qualifying as Medicare reimbursable expenses.

The demonstration project is scheduled to begin October 1, 1996 and end in September of 1999. The proposal calls for an evaluation of the demonstration by an external contractor acceptable to both DoD and HCFA. The evaluation contractor will provide an annual report, an interim report within 18 months of the commencement of the demonstration, and a final report six months after demonstration completion. Either party can withdraw from the demonstration with a twelve month written notice.

This proposal should provide evidence that HCFA will save Medicare funds by the implementation of Medicare Subvention. Medicare would be paying for the care of Medicare-eligible beneficiaries regardless if care is provided at a civilian medical facility or an MTF. The savings to Medicare would result for two reasons. First, Medicare will only reimburse 93 percent of the costs rather than 100 percent, and second, studies have shown that costs are less at an MTF compared to a civilian facility. Specifically, the 733 study concluded that it is 10 to 24 percent less costly to provide the same care at MTFs versus civilian facility.

# IV. MEDICARE SUBVENTION AND ACCESS TO CARE

## A. BACKGROUND

Receiving health care services at Military Treatment Facilities (MTFs) is an issue of concern for military retirees age 65 or older. In recent years, access to care at MTFs for Medicare-eligible retirees has become a challenge. Access refers to the ability to obtain admission to the medical system and receive care. Access can be limited by the number of providers, difficulty in obtaining appointments, and high prices charged to the patient. Only active duty members have guaranteed access to MTFs. Retirees and their dependents have access to MTFs only on a space available basis. This "available space" is diminishing with the closure of MTFs. Furthermore, the implementation of TRICARE will create a greater difficulty in obtaining access, unless there are changes to the existing policies.

Currently, MTFs receive no financial compensation for the provision of health care to military Medicare-eligible retirees. This fact impacts incentives for MTFs to initiate programs that would increase access to care for these retirees. In a 1995 interview, Defense Secretary William Perry, stated " retirees and dependents, age 65 and older, could be shut out of military medicine within the next two years unless Congress passes legislation requiring Medicare to reimburse the Department of Defense for cost of care they receive from the military" (Philpott, 1995, p. 14). Medicare Subvention is the legislation being proposed that would change this current policy of non-reimbursement for care by the Military Health Services System for Medicare-eligible retirees.

## B. ACCESS TO CARE SURVEY

In 1993, the Office of Program Analysis and Evaluation surveyed beneficiaries to obtain their view of the access they have to the direct care system. Table 1 on page 22 identifies the areas of interest and the data collected from the survey. (Office of Program Analysis and Evaluation, 1994, p.13) The data in Table 1 illustrates the difficulty retirees and dependents have accessing MTFs. Military Medicare-eligible retirees and their dependents would increase their opportunity to gain access to MTFs with the implementation of Medicare Subvention. Medicare Subvention would create incentives for MTFs to provide access to retirees and dependents, thus reducing their difficulties identified in Table 1.

## C. ACCESS TO CARE UNDER CHAMPUS

CHAMPUS eligibility affects the access to care for retirees and dependents by providing the option for them to receive care in the civilian community in addition to the MTF. This option, however, is not available to retirees age 65 or older. The law today does not allow military Medicare-eligible retirees to utilize the CHAMPUS system.

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) was established in 1966. CHAMPUS cost-shares with the beneficiary the expenses for care obtained in the civilian community when such care is not available or accessible at an MTF. The catchment area of an MTF is the dividing line for beneficiaries who must first seek care at an MTF. The term catchment area refers to a forty mile radius of an MTF or a geographic area defined by zip codes and certain geographical barriers such as rivers and

mountains. Beneficiaries within the catchment area are considered to be close enough to an MTF to receive care at that facility. A patient living within a catchment area will receive cost-shared reimbursement from CHAMPUS for care in the civilian community only after he or she has sought care at an MTF, been denied access for whatever reason, and received a Nonavailability Statement (NAS). However, certain routine outpatient services are exempt from the CHAMPUS NAS requirement. (Office of Program Analysis and Evaluation, 1994, pp. 11-12)

Beneficiaries living outside a catchment area are subject to different rules. These individuals have the option of seeking care at an MTF or going directly to a civilian provider. These beneficiaries file claims for CHAMPUS reimbursement for any covered services. A NAS is not required in order to receive CHAMPUS reimbursement. The only costs to these beneficiaries are their annual deductible and per visit co-payments. The distance from an MTF may reduce the frequency of visits to the facility and thus these beneficiaries do not significantly affect the access to MTFs for other beneficiaries.

Current policies prohibit military retirees age 65 or older from utilizing the CHAMPUS system. Once a retirees reach the age of 65, they are Medicare-eligible and no longer allowed reimbursement from CHAMPUS. This issue will be discussed further in a chapter devoted to Medicare.

Table 1

Access to Outpatient Care

| The survey done for this study sought the following information on access to outpatient care: | In general, persons receiving care from civilian facilities reported having somewhat greater access to those facilities than persons using military facilities did. Specifically: |
|---|---|
| The number of telephone calls required to make an appointment | About one in five users of military medical facilities said that they either had to make several calls to book an appointment or they were put on hold for a long time. This was true for fewer than one in twenty of those who chose civilian facilities. |
| The interval between the time an appointment was made and the date of the visit | More than 15 percent of beneficiaries who chose a military rather than a civilian facility had to wait more than two weeks for an appointment, compared to fewer than 6 percent of beneficiaries who selected a civilian facility. However, of those choosing a military facility, slightly more beneficiaries saw a provider the same day or the day after making an appointment |
| Travel time to the facility | Travel time to MTFs and civilian facilities was generally similar. A notable exception, however, occurred in the case of retirees, more than 20 percent of whom had to travel more than 45 minutes to reach a military facility. Of those using civilian facilities, only about 10 percent had travel times exceeding 45 minutes. |
| The amount of time spent in the waiting room | The proportion of beneficiaries reporting longer waiting times was greater for users of military facilities. A somewhat larger proportion of military users reported waits of more than 30 minutes: this difference was larger still for those who reported having to wait more than one hour (13 percent for users of military facilities versus 5 percent for civilian facility users). |

## D. ACCESS TO CARE UNDER TRICARE

The TRICARE Managed Care Program is the latest health care policy implemented by the Department of Defense. TRICARE is a regionally administered health care program for members of the uniformed services, their dependents, and other beneficiaries. Currently, TRICARE is in operation in a few areas of the country. However, by 1997, DoD plans to have managed care support contracts in all 12 DoD defined Health Service Regions. (Singer, 1995, pp. 1-14)

There are three options available under the TRICARE program; TRICARE Prime, TRICARE Standard, and TRICARE Extra. TRICARE Prime resembles HMO programs administered in the civilian health care sector. This option is composed of military providers and facilities, supplemented by civilian providers and facilities. TRICARE Prime coverage is very similar to the services covered under CHAMPUS. Although enrollment is required, there is no enrollment fee for dependents of active duty, and the enrollee is only responsible for a marginal co-payment that is charged for each visit to a civilian provider. Members of TRICARE Prime are allowed access to MTFs, but a referral is required from their Primary Care Manager (PCM).

PCMs are in charge of the health care needs of beneficiaries. If the PCM can not provide the necessary services, the beneficiary will be referred to the appropriate specialist within the provider network. This referral from the PCM must be obtained prior to receiving care from a specialist, or the beneficiary risks not being reimbursed for the cost of care. There is no co-payment charged when care is received at an MTF. Retirees under age 65 and their dependents are charged an enrollment fee plus a co-payment for

each visit to a civilian provider. (Office of Civilian Health and Medical Program of the Uniformed Services, 1995, pp. 1-2, Lamar, 1994, p.10)

TRICARE Prime is the option that DoD is encouraging active duty families to join. As stated earlier, this option allows enrollees to receive care at MTFs. However, the greater the number of active duty dependents receiving care at MTFs, the less "space available" remains for retirees and their dependents. (Singer, 1995, p. 7)

TRICARE Extra does not require enrollment, but does require a deductible. Under this program, beneficiaries are not required to obtain a referral from a PCM when seeking health care. However, the member is restricted to using providers that are in the TRICARE network. In this program, after their deductible is met, beneficiaries pay a reduced rate compared with Standard CHAMPUS.

TRICARE Standard offers the most flexibility of all the TRICARE options. This plan was previously known as CHAMPUS. As with TRICARE Extra, TRICARE Standard does not require enrollment, but does require a deductible. After their deductible is met, beneficiaries pay 20 percent of the negotiated rate for health care services. Under this plan, beneficiaries are not restricted to a network of providers. TRICARE Standard allows beneficiaries to continue to seek care from the provider they were using under CHAMPUS. However, additional out-of-pocket costs can be incurred if beneficiaries elect to receive care from "non-participating" providers.

Dependents of active duty personnel, retirees under age 65, and dependents of retirees under age 65 are eligible to participate in one of the three options of TRICARE. As with CHAMPUS however, retirees age 65 or older are not eligible to participate in any

of the TRICARE options. A legislative change is required to make DoD Medicare beneficiaries eligible for TRICARE.

This chapter identified some of the issues facing military Medicare-eligible retirees that negatively impact their access to care both in MTFs and at civilian facilities. Medicare Subvention alone will not solve the access problem for elderly retirees and their dependents, but it is a move in the right direction.

# V. THE EFFECT OF MEDICARE SUBVENTION ON MEDICARE

## A. MEDICARE BACKGROUND

Congress passed legislation in 1965 establishing the Medicare program as Title XVIII of the Social Security Act. Medicare was implemented on July 1,1966. Medicare was created to alleviate some of the financial burden of health care costs for the elderly.

At conception, Medicare covered only persons age 65 or older who received benefits under the Social Security or Railroad Retirement system, would have received benefits under the Social Security or Railroad Retirement system had they applied, or if an individual or their spouse had Medicare-covered government employment. Through legislation in 1972 and 1973, groups were added to be covered under Medicare. These groups include: persons who are entitled to disability benefits for 24 months or more, persons with end-stage renal disease requiring dialysis or kidney transplant, and persons not covered who elect to buy into the Medicare program. (HCFA Home Page, 1995)

Medicare is divided into two parts, Part A and Part B. Medicare Part A, also known as Hospital Insurance (HI), is provided in most cases automatically to persons age 65 or older and no monthly premium is charged to beneficiaries. Medicare Part B is optional and monthly premiums are charged to enrollees. When Medicare was implemented in 1966, 19.1 million persons were enrolled in the Medicare program. By 1994, 36.9 million persons were enrolled in one or both parts of the Medicare program. (HCFA Home Page, 1995)

Medicare Part A covers inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Part A has guidelines as to what is covered under Medicare for each service, what qualifies an individual for a service, and if and what deductible or copayment exists.

Medicare Part B primarily covers physician services. In addition, Part B covers clinical laboratory tests, durable medical equipment, flu vaccinations, drugs which can not be self-administered, therapy services, and certain other health care services. (HCFA Home Page, 1995)

## B. MEDICARE FINANCING

The Health Care Financing Administration (HCFA) is responsible for the finances of Medicare through the management of the Medicare Trust Fund. Authorization from HCFA is required for the release of funds from the Medicare Trust Fund for the reimbursement of health care services. The revenues necessary to cover the expenses of the Medicare program are generated from two sources, a payroll deduction and monthly premiums.

Medicare Part A is financed through the Federal Insurance Contribution Act (FICA). FICA is a mandatory payroll deduction which is deducted from employees' paychecks. This deduction is matched 100 percent by the employer for every employee. Currently, 1.45 percent of FICA is earmarked for the Medicare Trust Fund, the remainder going to the Social Security Trust Fund. The revenues generated by the 1.45 percent payroll deduction fund the expenses of the HI (HCFA Home Page, 1995).

Medicare Part B is financed through two sources, monthly premiums from enrollees and funds from the general revenues collected from tax payers. The current monthly premium charged to enrollees is $46.10. In most cases, these premiums are deducted from an individual's Social Security check. Currently, general revenues cover 75 percent of expenses of operating Medicare Part B. (HCFA Home Page, 1995)

## C. FINANCIAL DILEMMAS FACING MEDICARE

As stated above, revenues for Medicare are generated from employee payroll deductions, employer matched contributions, and the general fund. The Medicare Trust Fund will remain solvent as long as the number of people paying into the Medicare Trust Fund is larger than the number of beneficiaries of Medicare and funds collected cover the costs of the services provided for under Medicare. The concern for Medicare is that in the next decade, both of the requirements for solvency are predicted to change.

In the next decade, the "baby boomer generation" will begin qualifying for Medicare Part A. Based on census bureau data, the number of individuals in the age group that contributes into the Medicare Trust Fund is declining. When the "baby boomers" are eligible for Medicare Part A, the number of Medicare beneficiaries will out number those contributing to the program. Furthermore, expenditures for health care have steadily risen.

The balance of the Medicare Trust Fund and the projection of the contributions from payroll deductions indicate that in seven years the Medicare Trust Fund balance will be zero (HCFA Home Page, 1995). This situation is the cause of great concern for U.S.

citizens and the numerous debates over Medicare in Congress. If the policies of Medicare are not changed to reduce expenditures or increase the contributions to the Medicare Trust Fund, elderly persons will be in the same situation as their predecessors in pre 1966 days, i.e., unable to afford health care.

## D. SECTION 733 STUDY OF THE MILITARY MEDICAL CARE SYSTEM

Congress directed the study of the Military Medical Care System in Section 733 of the National Defense Authorization Act for Fiscal Years 1992 and 1993 (Lynn, 1994, p.1). The main purpose of the study was to determine the appropriate size and composition of the military medical system required to support the armed forces during a war or lesser conflict in the post-Cold War era. A second purpose of the study is more relevant to this thesis, that is, to ascertain what adjustments to the MHSS should be made to enhance the cost-effectiveness of the medical benefits provided during peacetime.

The Office of Program Analysis and Evaluation set out to determine if the medical care delivered to CHAMPUS beneficiaries is provided at less cost at MTFs or in civilian facilities. To accurately determine the answer to this question, identical services and all appropriate cost categories needed to be compared for both providers of care. (Lynn, 1994, p.5)

The 733 study concluded that it is less expensive to provide the identical care at MTFs than in a civilian facility under CHAMPUS. For a given workload, the study determined a price advantage of 10 to 24 percent for delivering care in MTFs (Lynn, 1994, p. 5)

## E. THE IMPACT OF THE 733 STUDY ON MEDICARE SUBVENTION AND MEDICARE

Currently the savings produced by providing care in MTFs have two effects. DoD saves by decreasing the funds paid out by CHAMPUS, and the beneficiary of the care saves by eliminating his or her out-of-pocket expenses. For Medicare to benefit from these savings, two things would have to be done. First, Medicare Subvention legislation would have to be passed. Medicare Subvention would allow MTFs to bill Medicare for care provided to military Medicare-eligible retirees. Second, a legislative change allowing military retirees age 65 or older to participate in CHAMPUS or TRICARE would need to be approved by Congress.

Medicare would pay for the care provided to Medicare beneficiaries whether the care is delivered in a civilian facility or an MTF. However, as the 733 study indicated, the cost of providing care is less expensive in MTFs, thus Medicare would save money. Through Medicare Subvention, the Medicare Trust Fund would save money every time a military Medicare-eligible retiree is treated at an MTF versus a civilian facility (Marine Corps Gazette, 1995, p. 4).

# VI. ENHANCING MILITARY READINESS THROUGH MEDICARE SUBVENTION

## A. BACKGROUND

Readiness is an essential element in determining the strength of the United States armed forces. Defense Secretary William J. Perry recently pledged "to make readiness the first priority, even at the expense of other important uses for the Department's resources" (Morrison, 1995, p.1). Readiness entails having U.S. forces that are appropriately manned, trained, and possess all necessary equipment to accomplish their tasks. Readiness of the armed forces also involves having the medical support required to treat injured troops and return them to their units as soon as possible.

Providing training and equipment to ensure a state of readiness requires the allocation of defense dollars. In the past decade, the portion of the federal budget appropriated for discretionary spending has declined, while at the same time funds appropriated to entitlements have increased. Specifically, the real budget authority for DoD has declined 35 percent in the past ten years (Congressional Budget Office, 1995, p.11). Funding for defense, and thus readiness, comes from discretionary funding. This shrinking of defense dollars has created a very competitive environment among each service as well as within each service.

During the Cold War, wartime medical requirements were based on the number of casualties that would arise from an all-out conventional war in Europe. The medical requirements identified in this period were almost three times greater than the capacity of

the military direct care system. (Singer, 1995, pp. 1-5)

The ending of the Cold War changed the national defense plan. Today, defense planning is based on the need to be able to win two nearly simultaneous Major Regional Conflicts (MRCs) (Congressional budget Office Papers, 1995, pp. 1-2). The direct care system that was inadequate to meet the wartime requirements of the Cold War is more than twice the estimated capacity required for this new defense plan (Singer, 1995, p. 2).

While this is positive, medical readiness problems still exist for the MHSS. Lessons learned from Desert Storm/Shield identified current problems facing medical readiness. Specific concerns identified include: deficient combat medical training for health care providers, inadequate medical personnel for mobilization and deployment systems, insufficient mobility of Army medical units, problems with the medical supply system, including equipment modernization and sustainment problems, and unfamiliarity of medical personnel with their deployment platforms. (Defense Science Board, 1994, p.1)

## B. READINESS OF ARMED FORCES VERSUS MEDICAL SUPPORT

Readiness of the forces that would be involved in military conflicts has long been realized as crucial. Training programs to enhance the skills of these forces have been a continual practice since their development. Furthermore, funding for training exercises has been available to meet the needs of the armed forces.

Equally important, but not receiving the same recognition, is the readiness of the MHSS. Medical support units are involved in almost every military action. Medical service personnel are called upon to augment the operating forces. For example, Navy

medical department personnel are required to be trained, deployable, and available to fully staff Deployable Medical Systems at the time armed forces are directed to respond to a national interest (Medical Resources, Plans and Policy Division, no date, p. 4).

Medical personnel attached to an operational unit accomplish two goals. In the event of casualties, which are a reality of military conflicts, medical personnel will be on location to provide the necessary casualty care. A corpsman or physician at the point of conflict provides stabilization of the wounded member until he or she can be transported to the appropriate echelon of care. Secondly, the augmentation of medical support with operational forces sends the message to our enemy that the U.S. has strong enough interest in an event that it is willing to accept casualties. This statement of commitment alone can deter the aggression of an enemy. Thus medical support can lead to the avoidance of casualties all together.

## C. THE EFFECT OF MEDICARE SUBVENTION ON THE READINESS OF MEDICAL PERSONNEL

Medicare Subvention could increase the quality of training medical personnel receive in MTFs. Access to care for military Medicare-eligible retirees would improve with the implementation of Medicare Subvention. Thus, the mix of patients that a physician, nurse, corpsman, or other medical staff member provides care to is larger. Without Medicare Subvention, MTFs' patients would primarily be young healthy active duty members. Furthermore, health care professionals must treat a wide variety of patients to meet certification standards and readiness requirements. The proficiency of

medical professionals is weakened by the lack of medical conditions presented by young active duty and their dependents. (Uniformed Services Journal, 1995, pp. 4-10)

The conditions that a military Medicare-eligible retiree presents to a medical staff member provides the closest training available to prepare medical personnel for conditions they may have to treat in areas overseas. The only training that would be of higher quality is treating actual combat casualties. The 65 and older population brings such conditions as thoracic surgery, organ transplant, and urology to the health care provider. For this reason, the military Medicare-eligible beneficiary population is a critical element of medical readiness. Figure 1 below, obtained from the Uniformed Services Journal, illustrates this point. (Uniformed Services Journal, 1995, p. 10, The Retired Officer Association, 1995, pp. 1-3)

## D. THE EFFECT OF MEDICARE SUBVENTION ON RETENTION

Retention of experienced medical personnel would be positively affected through Medicare Subvention. This legislation would increase the number of elderly military retirees receiving care at MTFs. Enlarging the number of treatments to this population group would provide enhanced training opportunities for military medical personnel. Training, job satisfaction, reasonable workloads, and fair compensation are factors that influence the decision of active duty medical personnel to pursue a military career. Increasing the number of quality personnel striving for a military career, while force reductions are occurring, heightens the opportunity to retain optimally trained personnel.

Retaining trained and experienced health care providers strengthens the readiness status of the medical system. On the other hand, readiness is reduced when experienced staff leave the military. The loss of trained and experienced health care providers results in a steeper learning curve due to the need to train new recruits. (Collins, 1994, pp. 19-21)

Retaining quality medical personnel is also dependent upon the reenlistment of junior military medical personnel. In many cases, recruiters and active duty senior military personnel advise junior military personnel, but are not the final factor determining whether a sailor or soldier reenlists. Often, members up for reenlistment seek the input of retired military veterans before making their decision. A favorable recommendation from a retiree usually leads to a reenlistment. Furthermore, the potential recruit will usually not enlist or reenlist without a positive response a military retiree. (Uniformed Services Journal, 1995, p. 7)

The perception of broken promises on the part of military retirees will not encourage them to make favorable recommendations to young service members. Medicare Subvention will enable military Medicare-eligible retirees to obtain access to care, thus maintaining a benefit they believe is due them for their service to their country. This in turn, may encourage them to recommend reenlistment to junior medical personnel seeking their advice.

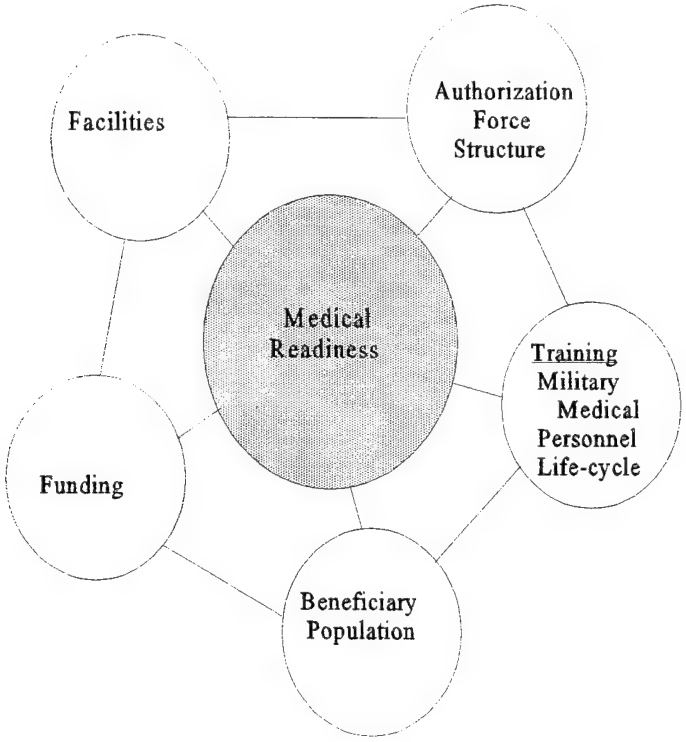


**Figure 1. Factors Effecting Medical Readiness**

# VII. CONCLUSIONS AND SUGGESTIONS FOR FUTURE RESEARCH

## A. CONCLUSIONS

The goal of this thesis was to explore Medicare Subvention and identify the effects this legislation would have on the Military Health Services System. Each chapter of this thesis addresses possible results Medicare Subvention would produce if passed.

Medicare Subvention legislation primarily impacts the reimbursement of Medicare dollars. If Medicare Subvention is approved by Congress, the Medicare Trust Fund will begin reimbursing DoD for care provided in MTFs to military Medicare-eligible retirees. Current laws prohibit reimbursement for these services. As discussed in chapter three, the Health Care Financing Administration controls the Medicare Trust Fund. Therefore, any legislation pertaining to the reimbursement of Medicare dollars involves HCFA.

Current estimates indicate that the Medicare Trust Fund is in jeopardy of reaching a zero balance by 2002. For this reason, changes to the existing policies of Medicare that would save the trust fund dollars would receive strong support from the general public. Medicare Subvention would provide a saving mechanism for the Medicare system. Studies have shown that it is less costly to provide care at an MTF versus a civilian facility. The 733 study stated that a 10 to 24 percent savings occurs from the delivery of care at an MTF, compared to the same care delivered from a civilian provider. Thus, savings to the Medicare Trust Fund would result for every additional military Medicare-eligible retiree that obtains care at an MTF rather than from a civilian provider.

Enactment of Medicare Subvention will improve access to MTFs for military Medicare-eligible retirees. It would allow MTFs to be reimbursed, thus increasing their incentives to provide care to these beneficiaries.

Military medical readiness would also be improved if Medicare Subvention legislation is passed. This legislation would increase the variety of cases military medical personnel would be exposed to. A greater patient mix would provide enhanced training and thus improve medical readiness. Increased training opportunities positively influence the desire of junior personnel to pursue a military career. Furthermore, increased training opportunity is an element that can lead to retention of junior medical personnel. Retention enhances medical readiness by maintaining the experience and knowledge of trained medical personnel.

The Medicare Subvention demonstration, a joint effort by HCFA and DoD, is scheduled to beginning October 1996 and end in September 1999. This demonstration is intended to show that both DoD and Medicare would benefit from the implementation of Medicare Subvention.

If Medicare Subvention is not passed by Congress, the retired military population age 65 and older will not receive a benefit that was promised to them for serving their country. These individuals believe that they should receive free medical care for repayment of their military career. Not immediately, but in time, this broken promise could result in a decrease of medical readiness and negatively affect the retention of trained and experienced junior medical personnel. If junior or mid-level military personnel believe that benefits promised to them will be denied when they retire, they may

decide to terminate their military career. This will result in the loss of trained personnel and produce a steeper leaning curve, thus reducing medical readiness.

## B. CONCERNS OF EFFECTS OF MEDICARE SUBVENTION

Currently, no copayment from a recipient of care in the direct care system exists. This results in high utilization in MTFs. Medicare Subvention most likely would result in a increased demand for care in MTFs from military Medicare-eligible retirees. If Medicare Subvention results in higher utilization of MTFs, where will additional space come from while MTFs continue to downsize and close?

Due to PAYGO, the entitlement portion of the federal budget is required to remain deficit neutral. Therefore, HCFA will not support any Medicare Subvention legislation that could result in an increase in expenditures from the Medicare Trust Fund. At the current rate of spending, the Medicare Trust Fund is expected to have a zero balance by 2002. Therefore, the future existence of Medicare is dependent upon programs that would reduce the outlay of Medicare funds.

## C. SUGGESTIONS FOR FUTURE RESEARCH

Future research could be conducted on the Medicare Subvention demonstration model. Specifically, did the demonstration model take place? If yes, does the generated data indicate the expected result that DoD and Medicare benefit from Medicare Subvention?

Future research could be applied to the Hefley and Cunningham bills to ascertain whether or not they became laws. If they became laws, it could be determined if the new laws have accomplished what they were intended to. That is, has access to care improved for military Medicare-eligible retirees? What other effects have occurred? How was opposition to Medicare Subvention overcome?

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